State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.medbd.ca.gov

CERTIFICATE OF CLINICAL TRAINING

[The completion of this form is required only of international medical school graduates, BUT may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school AND the medical school completes and certifies the "Official Breakdown of Undergraduate Clinical Clerkships form, Form L5A/B.] Please complete this form in the English language.

Complete ONE certificate for EACH clerkship, signed by the facility program director or instructor.

Only undergraduate clinical clerkships in which the applicant participated in **DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS IN A CLINICAL SETTING** should be reported on this form. Any clinical clerkships completed that do not meet the above criteria should NOT be reported on this form as they will NOT satisfy California's clinical training requirements.

This is to certify that _____; ____ ____ ____ / ____ ____ / ____ ____ ____ ____.
STUDENT'S NAME — U.S. SOCIAL SECURITY NO.:

_____ a student of _____.
DATE OF BIRTH-MM/DD/YYYY — MEDICAL SCHOOL

Completed a clerkship offered by _____
NAME AND ADDRESS OF FACILITY

From _____ through _____ in the clinical area
MONTH DAY YEAR — MONTH DAY YEAR

of _____.
CLINICAL AREA

This facility ❒ is affiliated with a U.S. or International school
❒ is NOT affiliated with a U.S. or International school

Name of U.S. or International medical school, if affiliated:

This facility ❒ does have an ACGME-accredited residency program in the areas of: _____.
❒ does not have an ACGME-accredited residency program.

ATTENTION FACILITY PROGRAM DIRECTORS OR INSTRUCTORS: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION.

Only the Facility Program Director or Instructor may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

I, _____ swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are strictly true in every respect.

Official Hospital Seal

_____
TYPE OR PRINT NAME OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR

_____
ADDRESS: NUMBER AND STREET

_____
CITY STATE ZIP CODE

_____ _____
TELEPHONE NUMBER SIGNATURE OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR

NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE FACILITY PROGRAM DIRECTOR OR INSTRUCTOR MUST SIGN THIS FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY SEAL.

Signed and sworn to before me this _____ day of _____ Month _____ Year

Notary Seal

_____
NOTARY PUBLIC

_____
ADDRESS

My Commissions Expires: _____

L6